

FILED JUN 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17518

BIRTH NO. _____		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 3076		Registrar's No. 86	
1. PLACE OF DEATH a. COUNTY Vernon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE Kansas b. COUNTY Bourbon admission).			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada Missouri		c. LENGTH OF STAY (in this place) 1 mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 416 S Eddy St 8158			
d. FULL NAME OF HOSPITAL OR INSTITUTION Wyatt Nursing Home				d. STREET ADDRESS (If rural, give location) Fort Scott Kansas			
3. NAME OF DECEASED (Type or Print)		a. (First) Edith		b. (Middle) P		c. (Last) Marlatt	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH 2-11-1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY homemaker		9. AGE (in years last birthday) 77		11. BIRTHPLACE (State or foreign country) Hopkins, Missouri 0	
13a. FATHER'S NAME James Driskel		13b. MOTHER'S MAIDEN NAME Ellen ?		14. NAME OF HUSBAND OR WIFE Jasper Marlatt (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Keeney Redfield, Kansas			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cornary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. History of Recurrent Cerebral Hemorrhage 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION				INTERVAL BETWEEN ONSET AND DEATH 12 hours ? One year	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-15 , 19 55 , to 5-19 , 19 55 , that I last saw the deceased alive on 5-18 , 19 55 , and that death occurred at 1:25 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE R. L. Morris		23b. ADDRESS M.D. Nevada, Mo.		23c. DATE SIGNED 5-24-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 19, 1955		24c. NAME OF CEMETERY OR CREMATORY Evergreen cemetery		24d. LOCATION (City, town, or county) (State) Fort Scott Kansas	
DATE REC'D BY LOCAL REG. 5-25-55		REGISTRAR'S SIGNATURE Anna E. Ferry		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Earl's Memorial Home Ft. Scott, Ks.			

(Licensed Emballer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 18 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

W. E. Kuntz

Licensed Embalmer No. *2080*

P. O. Address *P.O. Box 283*
Fort Scott, Kansas

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.